CHAPTER 11
SECTION 2.7

PSYCHIATRIC HOSPITALS ACCREDITATION

ISSUE DATE: July 14, 1993
AUTHORITY: 32 CFR 199.6(b)(4)(i) and (b)(4)(iv)

I. ISSUE

Psychiatric hospitals accreditation.

II. DESCRIPTION

A psychiatric hospital is an institution which is engaged primarily in providing services to inpatients for the diagnosis and treatment of mental disorders.

III. POLICY

In order for the services of a psychiatric hospital to be covered, the hospital shall comply with the provisions outlined in 32 CFR 199.6(b)(4)(i). All psychiatric hospitals shall be accredited under the JCAHO Accreditation Manual for Hospitals (AMH) standards in order for their services to be cost-shared. In the case of those psychiatric hospitals that are not JCAHO-accredited because they have not been in operation a sufficient period of time to be eligible to request an accreditation survey by the JCAHO, the Director, TRICARE, or a designee, may grant temporary approval if the hospital is certified and participating under Title XVIII of the Social Security Act (Medicare, Part A). This temporary approval expires 12 months from the date on which the psychiatric hospital first becomes eligible to request an accreditation survey by the JCAHO. For further information on accreditation of psychiatric hospitals refer to 32 CFR 199.6(b)(4)(iv).

FIGURE 11-2.7-1 PROGRAM INFORMATION NEW PSYCHIATRIC HOSPITAL PENDING JC ACCREDITATION, OCHAMPUS FORM 759

PROGRAM INFORMATION
NEW PSYCHIATRIC HOSPITAL
PENDING JC ACCREDITATION

FACILITY NO. _____
DATE _____

The information collected will assist the government in determining whether your facility can be considered an approved source of care for payment purposes under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The information will also aid the government in assisting CHAMPUS beneficiaries and representatives of the Uniformed Services in locating appropriate sources of care when there is a requirement for specialized care and treatment programs.

1. FACILITY NAME

2. FACILITY ADDRESS

3. IS YOUR FACILITY ADDRESS DIFFERENT FROM YOUR MAILING ADDRESS OR THE ADDRESS WHERE PAYMENTS ARE SENT?

❑ YES (INDICATE ADDRESS)

❑ NO

4. TELEPHONE NUMBER
( )

5. NAME AND TITLE OF CHIEF ADMINISTRATOR

6. ORGANIZATIONAL STRUCTURE: ❑ CORPORATION ❑ PARTNERSHIP ❑ SINGLE OWNER ❑ PUBLIC AGENCY ❑ PROFESSIONAL CORPORATION ❑ GROUP PRACTICE OR ASSOCIATION

7. TYPE OF OWNERSHIP: ❑ CITY ❑ COUNTY ❑ STATE ❑ PRIVATE NOT-FOR-PROFIT ❑ PRIVATE FOR PROFIT

8. FOR ADMISSIONS OR ACCEPTANCE INTO YOUR PROGRAM ARE THERE RESTRICTIONS BASED ON AN INDIVIDUAL'S RACE, COLOR, OR NATIONAL ORIGIN?

❑ YES ❑ NO

9. AFTER ADMISSION ARE PATIENTS TREATED EQUALLY WITHOUT REGARD TO RACE, COLOR OR NATIONAL ORIGIN?

❑ YES ❑ NO

10. TOTAL NUMBER OF UNITS IN YOUR FACILITY?

11. INDICATE HOW YOUR FACILITY RESTRICTS ADMISSIONS BY: SEX _____
AGE _____ GEOGRAPHIC AREA _____

12. IS THE COURSE OF TREATMENT FOR ALL PATIENTS PRESCRIBED AND SUPERVISED BY A PHYSICIAN?

❑ YES ❑ NO (EXPLAIN YOUR AGGANCEMENTS FOR PHYSICIANS SERVICES)

13. INDICATE THE SYSTEM(S) USED TO EVALUATE THE FACILITY'S PROGRAM:
CONTRACTUAL EVALUATION AND/OR PROGRAMMATIC CONSULTATION ❑ YES ❑ NO
PROFESSIONAL SERVICES REVIEW ORGANIZATION ❑ PARTICIPATE ❑ DO NOT PARTICIPATE
UTILIZATION REVIEW ❑ ACTIVE ❑ INACTIVE ❑ NONE ❑ N.A.
PATIENT REPRESENTATIVE ❑ YES ❑ NO
PATIENT, FAMILY OR STATE ADVISORY COMMITTEE ❑ ACTIVELY ❑ NOT ACTIVELY

14. PATIENT INFORMATION:

NUMBER OF LICENSED BEDS	NUMBER OF PATIENTS DURING THE LAST TWELVE MONTHS	CURRENT PATIENT CENSUS
_____	_____	_____

15. PROVIDE THE FOLLOWING ADDITIONAL INFORMATION:

a. Copy of state or local operating license.

b. A copy of your Medicare Certification Letter.

c. A copy of all correspondence with JCAHO.

d. Most recent state or local fire and health inspection reports.

e. Schedule of rates and charges for all services (Would charges for CHAMPUS beneficiaries differ from the charges incurred by others? If so, explain).

f. A current brochure, pamphlet, etc., describing your overall program.

16. NAME OF FACILITY REPRESENTATIVE	17. SIGNATURE	18. DATE

- END -